



**THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS
239 CAUSEWAY STREET, SUITE 500
BOSTON, MA 02114
617-973-0806
www.mass.gov/dph/boards/pa**

**SUPERVISING PHYSICIAN AND WORK SETTING INFORMATION FOR
TEMPORARY CERTIFICATE HOLDERS AND LICENSEES**

Complete all sections of this form and submit it to the Board within 30 days of beginning employment if you are:

1. adding an initial or additional supervising physician;
2. replacing your current supervising physician;
3. terminating a supervising physician; or
4. changing your work setting information.

Section I: PHYSICIAN ASSISTANT INFORMATION

Name: _____
Last First Middle License #

Address: _____
Number Street City/Town State Zip

Section II: SUPERVISING PHYSICIAN INFORMATION

If you are changing only your work setting information, please check "No change in supervising physician" and move to the next section

_____ **No change in supervising physician**
**Please fill out Work Setting Information in Section III*

_____ **Adding initial supervising physician:**

Initial Supervising Physician: _____
Last First MI License #

Effective Date: _____
**Please fill out Work Setting Information in Section III*

_____ **Adding additional supervising physician:**

New Supervising Physician: _____
Last First MI License #

Effective Date: _____

**Please fill out Work Setting Information in Section III*

_____ **Replacing supervising physician:**

Previous Supervising Physician: _____
Last First MI License #

New Supervising Physician: _____
Last First MI License #

Effective Date: _____

**Please fill out Work Setting Information in Section III*

_____ **Terminating supervising physician:**

Physician Name: _____
Last First MI License #

Effective Date: _____

TO BE COMPLETED BY SUPERVISING PHYSICIAN:

List all physician assistants currently under your supervision (attach additional pages as needed):

Name: _____ Lic. Number: _____

Name: _____ Lic. Number: _____

Name: _____ Lic. Number: _____

If you answer YES to any of the questions below, please submit a separate sheet with a detailed explanation.

Have you [the supervising physician] been disciplined [as defined by the Board of Registration in Medicine regulations] by any government authority, hospital or health care facility or professional medical association [international, national or local] within the past ten years from the date of this application?

_____ Yes _____ No

Within the last ten years from the date of this application, have you ever had staff privileges, employment or appointment in a hospital or health care institution denied, suspended or revoked?

_____ Yes _____ No

Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?

_____ Yes _____ No

I understand that, notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be in conformance with Board regulations at 263 CMR 5.04 and 5.05.

Signature of Supervising Physician

Date

Section III: WORK SETTING INFORMATION

Effective Date: _____

Name of Supervising Physician Associated with Work Setting: _____

Name of Facility or Office: _____

Address: _____

Type Facility: Office () Clinic () HMO () Hospital () Other: _____

Type Employment: Full time () Part time ()

List names of Massachusetts' hospitals at which you will practice or be affiliated with in this work setting:

Check all areas of practice that apply to this setting:

<input type="checkbox"/> Primary Care	<input type="checkbox"/> Administration	<input type="checkbox"/> Emergency Medicine
<input type="checkbox"/> General Surgery	<input type="checkbox"/> Internal medicine	<input type="checkbox"/> Occupational health
<input type="checkbox"/> Geriatric medicine	<input type="checkbox"/> Education	<input type="checkbox"/> Clinical research
<input type="checkbox"/> Obstetrics/Gyn.	<input type="checkbox"/> Pediatrics/Adolescents	
<input type="checkbox"/> Other (specify) _____		

Send this form within 30 days of beginning employment or any change in your supervising physician or work setting to: MA Board of Registration of Physician Assistants, 239 Causeway Street, Suite 500 5th Floor, Boston, MA 02114. Make a copy for your records. The Board is not able to provide copies of submitted forms. You will not receive confirmation of receipt by the board.